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ABSTRACT

As a part of the plan for Mental Health Manpower development for the State of Rhode Island (Department of Social Gerontological Research), a patient assessment survey of a random sample of the interviewable patients at the Institute of Mental Health Centers (CMHCs) in Rhode Island was conducted by the Hebrew Rehabilitation Center for Aged (HRCA). Analysis of the two samples separately using a multivariate clustering methodology with a clinical review revealed two distinct typologies, with no overlap in the types of clients found across the two samples. Among in-patients, 70% or six of the 10 types were judged able to return to the community, given needed supports. Among CMHC clients, less than 10% were over age 60, only 30% had ever been hospitalized, and only four of the 10 client types (27% of the sample) were judged vulnerable for future hospitalization. A separate survey of CMHC and IMH staff revealed that not only are CMHCs not serving chronic elderly patients, but that they are not currently performing the necessary tasks to effect the planned deinstitutionalization of such IMH patients. (Author)

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ELDERLY CHRONIC MENTAL PATIENTS:

IS THE COMMUNITY READY FOR THEM?

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This paper is based on findings from a NIMH federally funded mental health manpower development planning project undertaken by the Rhode Island Department of Mental Health, Retardation and Hospitals with a subcontract to the Hebrew Rehabilitation Center for Aged, Department of Social Gerontological Research.¹ Using data that were collected and processed by the Department of Social Gerontological Research, the analysis focuses in particular on the mental health manpower found to be currently operating in community settings in relation to meeting the needs of elderly and chronic mental patients. This is a particularly important issue in the face of continued efforts to deinstitutionalize elderly and chronic mental patients.

As part of the research aspects of the project, the Department of Social Gerontological Research conducted a patient assessment survey of a random sample of patients at the Institute of Mental Health (the State Hospital for the Mentally Ill) as well as a random sample of clients appearing for scheduled appointments at the 11 Community Mental Health Centers in Rhode Island.² In addition, the Department of Social Gerontological Research processed and helped analyze mental health manpower data. The findings to be presented below are drawn from these sources.

¹Funded by NIMH Contract #278-76-0019(11T).

²The clinical interviewers consisted not only of HRCA research clinicians but also of a number of members of the staff of the Institute of Mental Health who were specifically trained for this data collecting effort by the HRCA clinicians.

The major purpose of the surveys of institutional and community patients was to develop a typology of mental health patients and their associated needs which could be used as a management tool to facilitate the planning of services and staff requirements to deal with the large numbers of adult mental health clients (patients) within the framework of an individualized approach -- that is, the developing of services to meet the configuration of needs for different types of persons.

The data for both the institutional and community surveys were gathered through in-depth, clinically administered, structured interviews as well as systematic abstracting of records. The interview instrument consisted of a compilation of previously standardized scales, many of which, in addition to those used and found successful in previous studies of our own, were drawn from the Geriatric Mental Status Interview (Gurland, Copeland, Sharpe and Kelleher, 1977).

In all, 498 persons ranging in age from 14 to 90 were interviewed, 257 in the institutional sample and 241 in the community sample. Briefly, the analytic method consisted of the following steps: first, a multivariate statistical clustering of patients was completed on the basis of factor analytically derived theoretically important variables (psychological, social, behavioral and functional); secondly, the resultant clusters were reviewed by the HRCA interdisciplinary clinical team (usually consisting of a psychiatric nurse and a social worker) and slight adjustments in the membership of the clusters were made so that the members in each cluster presented a generally similar clinical picture. Once the decision was made that the members of a cluster were similar -- both in terms of their clinically relevant characteristics and their need for similar packages of services, the same interdisciplinary clinical team members set about developing cluster specific packages of service recommendations that best fit

the needs of the typical cluster member. The resultant clusters and recommendations were reviewed for final approval by a psychiatrist, Dr. Thomas Scaramella, the psychiatric consultant being called upon for input and approval at each stage of these research efforts, including the development of the survey assessment instrument and the final determination of the cluster assignment and cluster specific packages of services.

Analysis of the tasks performed by the mental health manpower in Rhode Island is being based on the returned responses to an anonymous pencil and paper questionnaire distributed by the Rhode Island Department of Mental Health, Retardation and Hospitals to all direct care staff as well as management in the institutional and community health systems. While a comparison of these two staff populations is, perhaps, of interest, the focus of this analysis is on the manpower and tasks performed by the Community Mental Health staff. There was an 85% response rate for the community staff.¹ The questionnaire was quite short, requiring less than twenty minutes to complete. Information gathered consisted of basic demographic data, length of related professional experience, training, professional membership and certification as well as staff's reported frequency of performing a series of 192 distinct behavioral tasks. The detailed task listing had been previously developed and tested and was found to factor into 14 broad domains of staff activities: intake; emergency services; diagnosis and assessment; supportive referral services; follow-up services; training; administration; research and evaluation; and prevention (University Research Corporation, 1976).

¹The response (return) rates for community and institutional staff were substantially different (85% and 45% respectively, although the first shift's return rate for institutional staff was 54%).

Pertinent to the issue of interest in this paper, findings from the patient assessment survey of the institutional sample reveal: (1) the extent to which there are persons for whom deinstitutionalization to a community setting is a reasonable goal; (2) the types of services that would be necessary to prepare such persons for release; and, particularly pertinent for the major focus of this analysis (3) the kinds of community services judged to be necessary for such persons to remain successfully in the community. At the same time, findings from the patient assessment of the community sample indicate the extent to which community centers are now serving the types of persons who are currently in an institutional setting but with potential for release to the community. Finally, also throwing light on the extent to which the community is ready for the elderly and chronic mental patient, findings concerning the task currently being performed by the Community Mental Health Center staff indicate the extent to which there needs to be a re-direction of staff efforts to meet the needs of the types of persons with potential for release from the mental institution into a community setting.

Findings

As might have been expected, the two study samples were found to be very different both demographically and clinically. For one, the Community Mental Health sample was much younger. With an age range of from 18 to 77 and a median age of 34, over 40% of the clients in the community sample were in the 25 to 35 year age group; only 10% were 60 years or older. While the institutional sample had a larger age range (from 14 to 90), the median age was considerably older, 52; and the majority of persons were in the middle-aged and elderly age groups. The institutional sample members were also less likely to be married and had a lower level of education. Furthermore, although 65%

of the institutional sample as compared with less than 35% of the community sample were male, institutional sample persons were less likely to have ever worked; and those who had worked were more likely to have worked at unskilled jobs. The two samples also differed radically in terms of institutional or mental health histories. Most of the institutionalized sample had been institutionalized for two years or longer. However, less than 30% of the Community Mental Health Center clients had ever been institutionalized. This implies that over 70% of the Community Mental Health Center clients had never had problems which led to the level of personal and social dysfunction associated with admission to a mental hospital. Even among those Community Mental Health Center clients who had been institutionalized, most had been in a mental hospital for less than a year. Few, if any, of the Community Mental Health Center sample members, therefore, could be considered to represent deinstitutionalized long-term or chronic mental patients. Indeed, even in the initial phase of interviewing of the community sample, this group appeared to be so different that the interview schedule used for the institutionalized population had to be modified.

Thus, while at the outset of the project it was expected that there would be greater overlap between the community and institutional samples, it soon became clear that the differences were very substantial and that the overlap between them (if any) would be very small. On this basis, the decision was made to develop a client typology separately for each group and then to compare the results.

Two very distinct typologies emerged -- 10 institutional clusters (i.e., types of persons) and 10 community clusters. There was no overlap in the types of clients found across the two samples. Among the in-patients, 6 of the 10

clusters representing almost 70% of the interviewable resident patient population were judged to consist either entirely or, for the most part, of persons who had the potential for return to the community: (1) following the receipt of institutionally based preparatory programming and (2) assuming the availability of adequate community supports. Charts A and B specify the preparatory and the post-release services considered necessary for successful deinstitutionalization; Chart C indicates what were clinically judged to be suitable post-release community settings for this population. As can be seen, not only do the "potentially releasable" persons currently remaining in the institutional setting need a great deal of in-house preparatory services and community services once released, but they also need a supportive residential setting.

Extrapolating the findings from this sample to the total estimated interviewable population in the Institute of Mental Health (the State Mental Hospital), it appears that there would be about 570 persons distributed within the six cluster types in which either all, or almost all, of the members tend to be assessed as having potential for release to a community setting. Considering the fact that within the remaining clusters there were at least some persons judged to have potential for release, 570 is probably a minimum figure.

Turning to the sample being served by the Community Mental Health Centers, only 4 of the 10 client types (but only about 2% of the sample) were judged vulnerable for future hospitalization in a long-term care mental facility. Most of those considered to be vulnerable had already had at least one, generally short-term, hospitalization. Chart D indicates the services considered appropriate for the Rhode Island community mental health sample.

In reviewing the charts, it should be understood that for each of the samples, the ten groups were labeled and ordered alphabetically according to a clinical criterion related to need for services. The criterion used for ordering the ten institutional clusters was a clinical judgment concerning the ability of group members to be successfully reintegrated into a community setting and the level of preparatory services which would be required to achieve deinstitutionalization. The criterion for ordering the ten Community Mental Health Center groups was in terms of a clinical determination of the degree to which group members would be "at risk" of experiencing a detrimental "life crisis" without mental health services. (Both sets of clusters are labeled A through J but this in no way implies the comparability of institutional and Community Mental Health Center clusters similarly labeled.) Comparing Chart B, the post-release service needs for the institutional clusters, with Chart D, the service needs of the current community mental health population, it can be readily seen that the pattern of service recommendations are very different. For the most part, the service needs are considerably less for the community clusters. Furthermore, while there were points of similarity in terms of one or two dimensions across the two sets of clusters, in no case were any of the Community Mental Health Centers of institutional groups sufficiently similar to be considered to have the same or comparable sets of service needs. The community and institutional clusters which resemble one another more than any other are institutional Cluster G and Community Mental Health Center Cluster H. Both groups are characterized by serious drinking problems and anti-social behavior as well as a relative absence of depression. However, the pervasiveness and degree of social dysfunction evidenced by institutional Cluster F is so much greater

than that of Community Mental Health Center Cluster H that there is a qualitative difference between the groups which has led to very distinct service recommendation packages. No other possible pair of Community Mental Health Center and institutional clusters resembled one another even to this extent.

The absence of any meaningful overlap between the populations (as represented by the two distinct survey samples) being served by the State institution and Community Mental Health Centers is perhaps one of the major findings of the client Retardation and Hospitals in relation to planning for and implementing a deinstitutionalization policy.

In addressing the manpower issues, it should be taken into consideration that the total number of full-time equivalent non-administrative staff in the Community Mental Health system is a little over 100, serving an active caseload of some 5,000 clients. An additional 570 clients (the additional potential deinstitutionalized population) might not seem to be an exorbitant jump unless one considers that less than 30% of the Community Mental Health Center's current caseload can be considered at-risk of breakdown and therefore, in need of the substantial amounts of time and other resources as would be required for the deinstitutionalized population. The community staff (assuming that they do serve the deinstitutionalized patient) will have to cope with almost a doubling of their current at-risk type of caseload and, at that, patients with perhaps even greater needs than those at-risk clients to whom community staff have been exposed. Thus, even assuming a staff flexible enough to adjust to and accommodate to these new patients, considerable additional staffing as well as organizational adjustment will be required to accommodate the new at-risk patients.

A comparison between the known capabilities of the staff, as measured by the tasks currently performed by them, with the tasks needed to meet the service goals of the dischargeable institutional patients also reveals some interesting insights. In terms of specific task performance, of the 25 most often noted tasks felt to be necessary to implement the recommended community services for deinstitutionalized patients, 18 related to the provision of supportive services, rehabilitation, referral activities and follow-up, while only seven referred to the provision of direct psychiatric therapies. While it may be argued that it is not the proper role of mental health professionals to perform supportive tasks such as preparing meals and supervising patients' day-to-day activities, the task of assisting clients in obtaining these services is unquestionably the responsibility of the mental health center if the Community Mental Health Centers are to have primary responsibility for deinstitutionalized patients.

Nonetheless, when such supportive tasks are provided at all, currently it is not the social workers but the nurses (or in some cases, the para-professionals) who perform them (a reasonable cost-efficient organizational model). It should be noted that there are only 12 nurse job lines in all of the 11 community clinics surveyed and a comparably small number of paraprofessional mental health workers. All 570 dischargeable patients represented by the six institutional clusters judged as having the potential to return to a community setting will require assistance in obtaining services, to a greater or lesser degree (depending on the number of different services needed, which as can be seen from Chart B, may be many). At the same time, only half of the 12 nurses and a fourth of the 40 social workers in the community engage in this task at least weekly. In fact, nearly half of the

community staff report never being involved in this activity, even though almost all are involved in intake, diagnostic and therapeutic tasks.

Another example from the domain of follow-up activities, "makes follow-up visits," will be needed by an estimated 400 patients, generally in the framework of an active after-care program. Nonetheless, most community nursing staff and social workers are engaged in this activity only monthly. For the most part, only the few nurses and paraprofessional community staff are involved in home visits and they only do these monthly. Rarely, if ever, do social workers report conducting home visits. Similar patterns of task performance also occur in the area of referral activities. Only in the area of direct therapeutic tasks such as conducting group or individual psychotherapy does the level of staff capabilities (in terms of current performance) appear to be sufficient to meet the expected needs of the to-be-deinstitutionalized patient.

It can, therefore, be seen that only a minority of Community Mental Health Center staff (primarily the small group of nurses employed) were performing any of the broad range of activities and tasks related to the provision or coordination of support services necessary for chronic and elderly patients believed by the interdisciplinary team to be crucial for successful deinstitutionalization. The bulk of Community Mental Health Center staff time is occupied in planning for and engaging in individual and group therapy. Very few Community Mental Health Center staff engaged in tasks classified as supportive or rehabilitative. While psychotherapy with elderly and chronic patients should not be dismissed as inappropriate, the therapeutic interaction in and of itself is probably not sufficient to enable community reintegration.

Once again, given the demands of an active client population of over 5,000 persons, it can be seen that the level of involvement of community staff in integrating institutional patients may not be sufficient to achieve this goal. Given the predominance of "not-at-risk" clients in the community caseload, there is a very real concern that the current organizational structure and staffing patterns of Community Mental Health clinics are not conducive to attaining community integration goals for deinstitutionalized patients.

Discussion

The findings from the survey of mental health clients and staff strongly point to the existence of two distinct and only loosely connected systems of service delivery. Institutional types of patients are not currently being seen in sufficient numbers in community clinics to have emerged as a definable group, although the move to deinstitutionalize mental hospital patients has been active over the past five years in Rhode Island (there has been a reduction of over 500 in the number of state mental hospital patients in this period). Although many of those deinstitutionalized may have been less needy without long histories of institutionalization, the obvious conclusion is that some other system of care (presumably nursing homes) has absorbed those of the chronic mental patients who were discharged, that the community clinics are not geared up to cope with a large wave of deinstitutionalized patients and the subsequent demand for supportive, rehabilitative and referral activities without substantial changes in staff patterns, organizational structure and purpose appears evident.

If the Rhode Island situation can be assumed to be comparable to that which exists in other areas of the country, unless substantial changes are made, there is ample reason to expect continued effort to deinstitutionalize

chronic mental patients to merely result in their being transferred to another institutional setting or to be "dumped" in one of the growing inner city "psychiatric shelters" without supports.

Furthermore, since there is little in the way of hard evidence that the Community Mental Health Centers are turning away deinstitutionalized persons that show up at their doors, the findings also suggest that greater liaison efforts are needed between the institution deinstitutionalizing patients and the Community Mental Health Centers -- that is, if the types of persons identified in the Rhode Island study as having potential for release to the community are to receive needed services through the Community Mental Health system.

CHART A: SUMMARY OF IN-HOUSE CLUSTER SPECIFIC SERVICE RECOMMENDATIONS

SERVICES	CLUSTERS						Majority Orientation Toward				
	Community Placement Orientation						Continued Institutionalization				
	A	B	C	D	E	F	G	H	I	J	
Mobility Training											
Self-Care Training											
Training and Monitoring in Use of Appliances											
Physical Therapy											
Continence Training											
Reality Orientation Program								X		X	
Controlled Introduction to Varied Stimuli								X		X	
Friendly Visitor (outside interpersonal contact)							X	X	X	X	
Recreational/Diversional Therapy	X		X	X	X		X	X	X	X	
Occupational Therapy			X				X	X	X	X	
Community Vocational Workshop			X	X	X						
Psychiatric Counseling, Individual-Supportive	X	X	X	X							
Psychiatric Counseling, Individual-Intensive Insight Oriented											
Psychiatric Counseling, Group	X	X	X	X	X	X	X	*			
Evaluation of Family Relationships	X	X	X	X	X	X					
Family Counseling - services	X	X	X		X						
Vocational Therapy/Counseling	X	X	X	X	X	X					
Behavior Modification Program	X	X		X		X			X		
Alcohol Treatment Program	X	X			X	X					
Drug Treatment Program	X										
Anti-Social Behavior Control Program	X	X				X					
Motivation for Independent Living				X	X		*	*			
Increase Patient Responsibility in Hospital				X	X		*	*			
Counseling to Overcome Fear of Community				X	X		*	*			
Out of Hospital Experience			X	X	X		X	X	X	X	
Program to Orient Respondent to Community Environment				X	X		*	*			
Communication Skills Training							X			X	
Training in Personal Hygiene and Attire			X	X	X		X	X	X	X	
Training in Interpersonal Skills			X	X	X	X		X	X	X	
Home Maintenance Training				X	X						
Training in Handling of Money				X	X		*	*			
Shopping/Errand Training and Experience				X	X		*	*			
Diet Training				X	X	X	*	*			
Food and Cooking Training				X	X						
Training in Self-Regulation of Medication		X	X	X	X	X	*	*			
Training in Use of Public Transportation				X	X		*	*			
Training in Use of Medical-Social Services System		X	X			X					
Overnight Community Preparation Visits			X	X	X		*	*			
Partial Hospitalization Program	X	X	X	X	X	X					
Guardianship											
Legal Services/Court Liaison/Advocate	X	X				X					
Escort Service Out of Hospital			X	X	X		X	X	X	X	
Transportation Out of Hospital			X	X	X		X	X	X	X	
Community Placement/House Finding Service	X	X	X	X	X	X	*	*			
Adult Basic Education	X										

* X means majority recommendations; * means only that portion for community placement.

CHAPT B: SUMMARY of POST-RELEASE COMMUNITY SERVICE RECOMMENDATIONS

SERVICES	CLUSTERS						Majority Orientation Toward			
	Community Placement Orientation						Continued Institutionalization			
	A	B	C	D	E	F	G	H	I	J
Physical Therapy										
Home Nursing										
Appliance Check/Maintenance										
Special Equipment/Ramps, Hospital Bed, etc.										
Meal Service (help)	X	X		X	X		X	X		
Light Housekeeping							X	X		
Household Errands							X	X		
Shopping				X			X	X		
Laundry				X			X	X		
Heavy House Cleaning					X		X	X		
Transportation				X			X	X		
Escort Service							X	X		
Daily Checking System	X		X	X	X		X	X		
Supervision of Medications/Appropriate Dosage Adjustment		X	X	X	X	X	X	X		
Medical Services		X		X	X	X	X	X		
Vocational Counseling/Placement	X	X	X	X		X				
Sheltered Workshop			X	X	X					
Occupational Therapy										
Recreation/Diversional Activities				X	X		X	X		
Friendly Visitor		X			X	X	X	X		
Interpersonal Skill Training			X	X	X	X				
Home Maintenance Training				X						
Family Counseling	X	X				X				
Provision of Family Services	X									
Psychiatric Counseling, Individual-Supportive	X		X							
Psychiatric Counseling, Individual-Intensive Insight Oriented										
Psychiatric Counseling, Group	X	X		X	X	X	X	X		
Drug Treatment Program	X									
Alcohol Treatment Program	X	X			X	X				
Structured Behavior Modification Program	X	X				X				
Day Care Program		X	X							
After Care Program			X	X	X	X	X	X		
Legal Services/Court Liaison/Advocate	X	X				X				
Adult Basic Education/High School	X									
Psychiatric Counseling, Individual - Short-term										
Marital Counseling, Couple										

*X means minority recommendations.

CHART C: SUMMARY OF CLUSTER SPECIFIC FACILITY RECOMMENDATIONS

SERVICES	CLUSTERS Community Placement Orientation						Majority Orientation Toward Continued Institutionalization			
	A	B	C	D	E	F	G	H	I	J
COMMUNITY PLACEMENT OPTIONS	/	/	/	/	/	/	/	/	/	/
INDEPENDENT	/	/	/	/	/	/	/	/	/	/
Own Apartment, Room - no restrictions										
Shared Apartment, No monitoring required										
INDEPENDENT IN SHELTERED HOUSING	/	/	/	/	/	/	/	/	/	/
Own Apartment - complex for elderly										
Own Apartment - medically (psychiatrically) oriented sheltered housing - one meal and bi-weekly cleaning service										
Own Apartment - medically (psychiatrically) oriented sheltered housing - one meal, cleaning and 24 hour medical/psychiatric contact										
DEPENDENT, STRUCTURED ENVIRONMENT	/	/	/	/	/	/	/	/	/	/
With Others - relatives or friends, dependent monitored situation (if family or friends available)			X ¹							
Cooperative Apartments - sharing apartment with others periodic contact and supervision from mental health system worker			X ²							
Half-Way House - intensive therapeutic or rehabilitation environment - shared responsibility, communal meals - supervision with goal of further independence (time limited placement)	X ¹	X ¹	X ³							
Group Home - maintenance environment, structured with communal meals, supervision and shared responsibilities; greater staff support	X ²	X ²	X ⁴	X ¹	X ³	X ¹				
Foster Home, Individual - dependent living					X ²		X ²	X ²		
Foster Home, Group - dependent living				X ²	X ¹		X ¹	X ³		
INSTITUTION	/	/	/	/	/	/	/	/	/	/
Nursing Home										
Psychiatric Facility (residential)							X ¹		X	X

*Minority post-release facility recommendations are X² and X³.

*X¹ means the primary facility recommendation; X² means the secondary facility recommendation; X³ means the tertiary facility recommendation.

CHART D: SUMMARY OF COMMUNITY SERVICE RECOMMENDATIONS

SERVICES	COMMUNITY CLUSTERS									
	A	B	C	D	E	F	G	H	I	J
Physical Therapy										
Home Nursing										
Appliance Check/Maintenance										
Special Equipment/Ramps, Hospital Bed, etc.										
Meal Service (help)										X
Light Housekeeping										X
Household Errands										X
Shopping										X
Laundry										X
Heavy House Cleaning										X
Transportation										X
Escort Service										
Daily Checking System										
Supervision of Medications/Appropriate Dosage Adjustment								X	X	X
Medical Services										X
Vocational Counseling/Placement							X	X	X	X
Sheltered Workshop										X
Occupational Therapy										
Recreational/Diversional Activities		X								X
Friendly Visitor										X
Interpersonal Skill Training - Development								X		X
Home Maintenance Training										X
Family Counseling										
Provision of Family Services										
Psychiatric Counseling, Individual - Supportive				X	X	X				
Psychiatric Counseling, Individual-Intensive Insight Oriented			X							
Psychiatric Counseling, Group				X			X	X	X	X
Drug Treatment Program								X		
Alcohol Treatment Program/Outpatient/A.A.						X		X		
Structured Behavior Modification Program										
Day Care Program										
After Care Program										
Legal Services/Court Liaison/Advocate										
Adult Basic Education/High School										
Psychiatric Counseling - Individual Short-term	X	X								
Marital Counseling - Couple			X							

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